STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	**1501 INVERNESS DR LAWRENCE, KS 66047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00068800. A revised 2567 was sent to the facility on 9/30/13.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 110 residents. The sample included 15 residents. Based on observation, record review, and interviews the facility failed to allow resident (#2) from the 3 reviewed for chooses to choose his/her scheduled bedtime. Findings included: - Resident #2's quarterly minimum Data Set (MDS) 3.0 assessment dated 8/19/13, recorded the resident with a Brief Interview for Mental Status score of 12 which indicated the resident had moderately impaired cognition, the resident did not have any mood or behaviors exhibited during the review period, and required extensive to total assistance of one to two staff members with most activities of daily living.	F 242		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The annual Care Area Assessment (CAA) dated 6/3/13 for cognition recorded the resident was alert and oriented to person, place, and time and had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance.
Review of the care plan dated 5/30/13 directed staff to encourage the resident to make routine decisions and noted the resident prefers to go to bed around 8:00 P.M.

On 9/17/13 at 2:00 P.M. observation revealed the resident in the dining room, seated alone and eating lunch.

On 9/17/13 at 2:10 P.M. the resident stated that he/she did not like to stay up late and would prefer going to bed at 7:00 PM. but rarely got to go to bed at that time. The resident stated that staff was aware but they did what they wanted.

On 9/18/13 at 3:00 P.M. licensed nurse K stated the resident usually goes to bed between 7:00 P.M. and 7:30 P.M. but the resident said it to him/her that it was closer to 8:00 P.M. or 9:00 P.M. Licensed nurse K told the resident the same people can not go to bed early every night.

On 9/19/13 at 8:35 A.M. direct care staff Q stated the resident went to bed right after supper, but then looked at the resident's care plan and said the care plan said the resident went to bed at 8:00 P.M.

The facility did not provide a policy related to resident rights to choose their bedtime.

On 9/19/13 at 4:30 P.M. administrative licensed nurse G said he/she was not aware the resident

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F 242	Continued From page 2 changed his/her requested bed time. The facility failed to allow this resident to schedule his/her bedtime at a time of his/her choosing.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 110 residents. Based on observation and interview the facility failed to identify individual linens in the residents' bathrooms for 3 of 4 days on site. Findings included: - Observations on 9/16/13 from 9:00 A.M. to 5:15 P.M., 9/17/13 from 7:00 A.M. to 5:15 P.M. and 9/18/13 from 7:00 A.M. to 5:30 P.M. revealed sampled residents #22, # 40, #53, #109, #28 rooms lacked resident identification on the towel bars. Interview with maintenance staff X on 9/18/13 at 1:50 P.M. acknowledged the lack of identification and stated he/she was not sure how residents were to know which towels were theirs. The facility failed to provide individual bathroom linens accommodation of resident's needs.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 110 residents and the sample was 15. Based on observation, record review, and interview the facility failed to revise the care plan for individual behaviors for 2 (#125, #167) of 15 resident reviewed for care plans.

Findings included:

- Resident #125's quarterly Minimum Data Set (MDS) 3.0 dated 4/14/13 recorded the resident Brief Interview for Mental Status was not competed due to lack of the residents understanding. The MDS recorded the resident

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required limited assistance with eating, extensive assistance with bed mobility, transfers, dressing, and total assistance with toilet use, and personal hygiene.

The Care Area Assessment dated 1/22/13 for dementia recorded the resident's cognitive loss affected his/her thinking and the resident had behaviors and anxiety. He/she infrequently struck out at staff during care and frequently had problems in the afternoon with restlessness.

The care plan dated 9/13/13 documented staff to offer non-pharmacological interventions when behaviors occurred and staff to monitor for the targeted reason for which staff administered the medications.

The Medication Administration Record documented monitoring behaviors of increased anxiety, combativeness, attempting to stand and swinging at staff.

Observation of the resident on 9/17/13 at 2:35 P.M. revealed the resident sat in his/her wheelchair and watched other residents. The resident was calm.

Observation of the resident on 9/18/13 at 3:19 P.M. revealed the resident sat in his/her wheelchair at the table and placed bean bags in a basket. The resident was calm.

Interview with licensed staff I on 9/18/13 at 4:15 P.M. stated the resident was combative at times when staff were changing him/her. Staff acknowledged the lack of behaviors on the care plan and stated the nurses did not update the care plans, only the MDS coordinator updated the

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care plans.

Interview with direct care staff O on 9/18/13 stated the resident was cooperative when you knew how to approach him/her. Staff did not document behaviors.

Interview with administrative licensed staff E on 9/18/13 at 4:35 P.M. acknowledged the care plan stated the resident had behaviors but did not specify what the behaviors were.

Interview with administrative licensed staff F on 9/18/13 at 4:36 P.M. stated he/she did not document behaviors when he/she wrote the care plan and did not know how staff knew what behaviors the resident had.

The facility policy dated 7/1/10 documented persons responsible for updates to the care plan included licensed nurses, rehab, social services and dietary.

The facility failed to revise the care plan regarding specific behaviors for this resident.

- The August 2013 Physician's Order Sheet for resident #167 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).

The 5 day Minimum Data Set 3.0 (MDS) dated 8/27/13 noted short term and long term memory problems. The resident was not able to recall the

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current location of his/her own room, staff names or faces, the season, or that he/she was in a nursing home. His/her cognitive skills for daily decision making were moderately impaired; decisions poor and cues/supervision required. The resident did not exhibit any mood or behaviors.

The Care Area Assessment (CAA) dated 8/9/13 for cognition noted the resident had a diagnosis of dementia. The resident wandered and was unable to follow simple directions.

The CAA for mood did not trigger.

The care plan dated 8/9/13 noted staff were to be aware of non-pharmacological interventions that reduced the resident's behaviors. The care plan lacked specific interventions.

Observation on 9/17/13 at 4:00 P.M. the resident rested in bed with eyes closed and appeared calm.

Interview on 9/19/13 at 9:10 A.M. licensed nursing staff H stated this resident no longer exhibited behaviors.

Interview on 9/18/13 at 4:15 P.M. licensed nursing staff I stated the MDS coordinator updated the care plan.

The facility policy "Plan of Care Development and Communication Tool Guidelines" dated 7/1/10 noted "the resident's care plan will be periodically reviewed and revised by the Interdisciplinary Team".

The facility failed to revise the care plan to reflect

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F 280	Continued From page 7 this resident's behaviors.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility identified a census of 110 residents. The sample included 15 residents, of which 3 were reviewed for Activities of Daily Living (ADL) care. Based on observation, record review and interview, the facility failed to provide ADL care for one (#167) resident of the sample. Findings included: - The August 2013 Physician's Order Sheet for resident #167 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). The 5 day Minimum Data Set 3.0 (MDS) dated 8/27/13 noted short term and long term memory problems. The resident was not able to recall the current location of his/her own room, staff names or faces, the season, or that he/she was in a nursing home. His/her cognitive skills for daily decision making were moderately impaired; decisions poor and cues/supervision required. The resident required extensive assistance of one staff with personal hygiene.	F 312		

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The Care Area Assessment (CAA) dated 8/9/13 for cognition noted the resident had a diagnosis of dementia. The CAA for ADL/Rehabilitation status did not trigger.

Observation on 09/16/2013 12:17 P.M. the resident had pureed food in mouth leaking out of his/her mouth.

Observation on 9/19/13 at 8:00 A.M. the resident sat in the living room after breakfast. He/she had food tainted saliva running out of his/her mouth. From 8:20 A.M. to 8:25 A.M. direct care staff P spoke with resident, but failed to clean the resident's face. At 8:45 A.M. a direct care staff gave the resident a drink of juice, and cleaned his/her face.

Interview on 9/19/13 9:00 A.M. direct care staff Q stated if he/she noticed a resident with food on his/her face, he/she promptly cleaned his/her face.

Interview on 9/19/13 at 2:15 P.M. direct care staff R stated if he/she noticed a resident with food on his/her face, he/she promptly cleaned his/her face.

Interview on 9/19/13 at 9:10 A.M. licensed nursing staff H stated if he/she noticed a resident with food on his/her face, he/she promptly cleaned his/her face.

Interview on 9/19/13 at 2:40 P.M. licensed nursing staff J stated if he/she noticed a resident with food on his/her face, he/she promptly cleaned his/her face.

Interview on 9/19/13 at 1:05 P.M. administrative

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F 312	Continued From page 9 nursing staff D stated nursing staff were expected to keep residents' face clean. The facility failed to provide a policy related to ADL care. The facility failed to clean this cognitively impaired and dependent resident's face when it was soiled with food/drink.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 110 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure each resident received adequate supervision and assistive devices as planned to prevent accidents for 1 (#102) of 3 residents reviewed for falls. Findings included: - The August 2013 Physician's Order Sheet for resident #102 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).	F 323		

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The Quarterly Minimum Data Set 3.0 (MDS) dated 7/28/13 noted a Brief Interview for Mental Status score of 10 (8 to 12 indicated moderately impaired cognition). It documented the resident required extensive assistance of two staff for transfers.

The Care Area Assessment (CAA) dated 4/27/13 for cognition did not trigger.

The Care Area Assessment (CAA) dated 4/27/13 for Activities of Daily Living (ADLs)/Rehabilitation status noted the resident required extensive assistance with ADLs.

The care plan dated 8/1/13 for falls noted staff were to keep the resident's call light within reach.

Review of the facility's fall investigation reports, staff reported falls for this resident on 4/20/13, 5/1/13, 5/21/13, 5/29/13, 6/5/13, 6/20/13, 6/21/13, and 9/14/13.

Observation on 9/17/13 at 4:00 P.M. the resident rested in bed and the call light was in the recliner.

Observation on 9/18/13 at 9:30 A.M. the resident rested in bed and the call light was in the recliner.

Interview on 9/19/13 at 9:00 A.M. direct care staff Q stated to prevent a resident from falling, he/she ensured the call light was within reach of the resident.

Interview on 9/19/13 at 4:15 P.M. direct care staff R stated to prevent a resident from falling, he/she ensured the call light was within reach of the resident.

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F 323	Continued From page 11 The facility failed to provide a policy related to preventing resident falls. The facility failed to keep the call light within reach of this resident with previous falls.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 110 residents. The sample included 15 residents. Based on	F 329		

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observation, record review and interview, the facility failed to follow the pulse parameters for a resident who received anit-hypertensives (#10), and monitor medication for bowel movements (#167).

Findings included:

- Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated 6/4/13, recorded the resident with a Brief Interview For Mental Status (BIMS) score of 9 which indicated the resident had moderately impaired cognition, and required extensive assistance of one staff member with bed mobility, transfers, dressing, toilet use, and limited assistance of one staff member with locomotion on the unit and eating. This same assessment recorded the resident received anti-hypertensive medications (medications used to control high blood pressure.

Review of the September 2013 physician order sheet, (POS) revealed a physician order dated 6/6/10 to "notify the physician if blood pressure reading on Tuesday is greater than 140/90 millimeters of mercury (mm/hgb)or pulse is less than 60 beats per minute (bpm), or greater that 90 beats per minute".

Review of the care plan dated 6/27/13 recorded the resident received routine pain relief medication but lacked documentation the resident used anti-hypertensive medications.

Review of the September 2013 medication administration record (MAR) revealed the resident pulse exceeded 90 bpm on 9/3/13 (93 bpm) and 9/18/13 (97 bpm)

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Review of the nurses progress notes dated 9/3/13 and 9/18/13 respectively lacked documentation staff notified the physician of the residents elevated pulse reading,

On 9/18/13 at 8:20 A.M. the resident ambulated with his/her walker and staff assistance to the shower room.

On 9/191/13 at 10:00 A.M. administrative nurse C said he/she was unaware the physician was not notified of the residents elevated pulse.

The facility policy title Medication Management revised 5/28/02 lacked documentation regarding the notification of the physician for out-of-parameter blood pressure and pulse readings,

The facility failed to follow physician's orders regarding the resident's blood pressure and pulse readings.

- The August 2013 Physician's Order Sheet for resident #167 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). It revealed orders for Celexa (a medication to help with depression) and Risperdal (a medication to help with behaviors).

A physician's order dated 8/30/13 for Dulcolax suppository (a medication to relieve hard stools) to be given if the resident did not have a bowel movement every 3 days.

The 5 day Minimum Data Set 3.0 (MDS) dated 8/27/13 noted short term and long term memory

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problems. The resident was not able to recall the current location of his/her own room, staff names or faces, the season, or that he/she was in a nursing home. His/her cognitive skills for daily decision making were moderately impaired; decisions poor and cues/supervision required.

The Care Area Assessment (CAA) dated 8/9/13 for cognition noted the resident had a diagnosis of dementia. The resident wandered, and was unable to follow simple directions.

The care plan dated 8/9/13 noted staff encouraged the resident to make routine, daily decisions, helped the resident through the decision-making process, not rush the resident or show impatience, and give positive feedback when the resident made a decision.

Lexi-Comp's Drug Information Handbook for Nursing, 12th Edition, noted Celexa and Risperdal could cause constipation.

Bowel monitoring forms for August 2013 and September 2013 noted the resident was admitted on 8/1/13, and staff failed to record a bowel movement (BM) until 8/11/13. There was no BM documented from 9/8/13 to 9/16/13.

Review of the Medication Administration Records for August 2013 and September 2013 failed to document the administration of Dulcolax.

Interview on 9/19/13 at 9:00 A.M. direct care staff Q stated staff documented on the computer when a resident had a BM.

Interview on 9/19/13 at 2:40 P.M. licensed nursing staff J stated the direct care staff notified

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F 329	Continued From page 15 the licensed nurse if a resident did not have a BM in 3 days. He/she said there was a print out of which residents did not have a BM in 3 days. Interview on 9/19/13 at 9:50 A.M. administrative nursing staff C stated the staff nurse looked at the bowel movement trend in the computer program. The facility failed to provide a policy on bowel monitoring. The facility failed to effectively monitor bowel movements and failed to administer the as needed medication for constipation for this resident.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility had a census of 110 residents. The sample included 15 residents. Based on observation, record review and interview, the facility failed to prepare, store, distribute and serve food under sanitary conditions for the residents residing in the facility who received their	F 371		

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meals from 2 of the 2 kitchens.

Findings included:

- On 9/16/2013, at 8:45 AM, during the initial tour of the south kitchen, observation revealed Dietary Staff EE in the kitchen, preparing food and washing dishes for the residents, had a ball cap on and hair coming out of the sides and the back of the cap and a uncovered beard. During the initial tour of the north kitchen observation revealed dietary staff FF assisting staff with preparation of food in the kitchen, with hair and beard uncovered.

On 9/18/2013 at 12:45 PM, dietary staff DD verified the staff were to entirely cover their hair and beard while working in the kitchen during preparation and distribution of food for the residents.

The facility's 8/06/2012, dress code policy for personal requirements for food service employees revealed the Dietary Services Department employees adhere to a facility code that facilitates safe, sanitary meal production and services, and presents a professional appearance. The policy indicated the employees hair is to be completely covered and restrained with a hair net or hair bouffant (disposable hair cover) while in the food preparation area and/or in the kitchen.

The facility failed to prepare, distribute, and serve food under sanitary conditions, for the 110 residents residing in the facility who received meals from the 2 kitchens.

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F 371	Continued From page 17 - On 9/18/13 at 8:45 AM, observation revealed 3 overhead sprinklers above the food preparation stove with gray lint hanging from the end of the spickets. Further observation revealed thick gray lint on the top of the triple water processing bottles and on the wall behind the stove, and a corner of the base board tile along the corner of the entrance to the freezer had chunks of tile missing with exposed concrete. On 9/18/2013 at 12:30 PM, dietary staff DD verified the cleaning schedule for the south kitchen lacked documentation of a date or time the dietary staff cleaned the kitchen in month of September 2013. On 09/19/13 at 12:45 PM, dietary staff DD verified the overhead water spickets, and the triple water processing system was covered with gray lint. Dietary staff DD verified the dietary staff were to clean the area above the stove but was unsure of the cleaning schedule. Dietary staff DD verified the missing baseboard in the kitchen. The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 70 residents who received meals from the main kitchen.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 110 residents, of which 40 residents reside in the North building, and 70 residents reside in the South building. Based on observation and interview, the facility failed to ensure a medication cart in one of two buildings, with accessible medications and narcotics were locked or under direct supervision of staff. The facility identified 4 cognitively impaired independently mobile residents who resided in the North building. The facility failed to

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dispose of expired medication in 1 of 3 medication rooms, and failed to properly date opening on vial/package in 2 of 3 medication rooms in the South building.

Findings included:

On 9/19/2013 at 2:45 PM, observation of the North building/A hall, revealed one of the facility medication carts with a drawer unlocked, pulled out, containing medications in blister packs and narcotic medications and no staff/nurse in attendance. Continued observation revealed Nurse T left the cart unattended for approximately 2 minutes. Observation of the unlocked medication cart revealed two floor/contractor workers carrying a roll of linoleum down the hall in front of the open cart and into a resident's room. Further observation revealed a transportation employee pushed a resident in a wheelchair into the building in front of the unattended/open medication cart.

On 10/13/2011 at 8:55 AM, administrative nurse II verified the nursing staff are not to leave the medication cart unattended when opened, and should ensure the cart is locked when the staff are not in attendance.

The 5/28/202 facility policy for Medication Management Guidelines instructed the staff to store medication in a lighted, locked storage area accessible to authorized personnel only. The policy stated to have medication carts in a locked room or otherwise made immobile. All mobile medication carts must be under visual control of the nurse at all times when in use.

The facility failed to provide safe and secure

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F 431	Continued From page 20 storage of medication for the safety of 4 cognitively impaired residents that reside in the north building of the facility. - On initial tour 9/16/13 at 8:50 A.M. the medication room on the 400 to 500 unit had one undated Tubersol (TB) vial. An interview with administrative licensed nurse F on 9/16/13 at 8:50 A.M. stated the staff were expected to date the vial when it was opened. The facility failed to date a vial of Tubersol when opened. - On initial tour on 9/16/13 at 9:25 A.M. review of the medication room on the 100, 200, 300 nursing units noted 3 undated insulins and 1 expired insulin. An interview with licensed staff H on 9/16/13 at 9:25 A.M. acknowledged the undated and expired medications. He/she stated staff were to date insulin when it was opened the insulin was to be dated when they were opened. The facility failed to timely dispose of expired medications.	F 431		
F 463	. 483.70(f) RESIDENT CALL SYSTEM -	F 463		

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F 463 SS=E	Continued From page 21 ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility reported a census of 110 residents. Based on observation, record review, and interview the facility failed to ensure a functioning call light system. Findings included: - Observation on 9/17/13 at 10:35 A.M. revealed one light in the spa room on the 300 hall, one light on 500 hall and one light on C hall did not function properly. Record review of the call light log recorded the call lights in every room were monitored monthly. Interview with maintenance staff X on 9/18/13 at 2:35 P.M. stated the whole building was checked monthly for call light function. The call lights were checked weekly but only for random rooms and was not documented. The facility failed to provide a functional call system.	F 463		